MARYLAND TRAUMA PHYSICIAN SERVICES FUND

Annual Reconciliation

Physician Uncompensated Care

MARYLAND HEALTH CARE COMMISSION

Marilyn Moon, PhD
Chair

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Executive Director

HEALTH SERVICES COST REVIEW COMMISSION

Irvin W. Kues
Chairman

Robert Murray
Executive Director

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Revised November 21, 2007

You Must File

IF . . .

- You provide services to a trauma patient with no health insurance, including Medicare Part B coverage, VA health benefits, CHAMPUS, Worker's Compensation, and is not eligible for Medical Assistance coverage., even if you received no subsequent payment.

- You received uncompensated care payments from the Fund and subsequently received payments from the patient, Medicare, Medicaid, the VA, Workmen's Compensation, CHAMPUS, a health insurance company, automobile insurance company, or an attorney as a result of a legal settlement.

Please remember…

If you received a subsequent payment for a trauma patient that was previously paid by the Fund, you must report it even though the payment is less than your practice's original billed amount.

1. Application Submission Date:

Month Day Year

2. Practice Information:

Name of physician, practice, or center

Street Address

City State

Zip Code Area Code + Telephone Number

E-mail Address

3. Contact person if additional application information is needed:

Name Title

Street Address

City State

Zip Code Area Code + Telephone Number

E-mail Address

4. Trauma Center where care was provided:

5. During this reporting period, was money recovered from another payer source for past services declared and reimbursed under the Fund? Please report the amount paid to you by other sources for which your practice had previously received uncompensated care (Trauma Fund) payments. $

PLEASE PROVIDE
PHYSICIAN, PATIENT, SERVICE & FINANCIAL INFORMATION
IN THE FOLLOWING TABLE IF THE AMOUNT REPORT IN
QUESTION 5 IS GREATER THAN 0.

Note: "Table Definitions" follow each table.

TABLE 1 Patient Reconciliation Report

Patient Last Name	Facility ID #	Trauma Registry #	Social Security #	EOB (IF Applicable)	Start of Service	End of Service	Total Amount Received from Trauma Fund	Source of Additional Funds (see Table Definition)	Other Payment Received	Amount Returned to Trauma Fund

TABLE DEFINITIONS – PATIENT INFORMATION

Patient Name – The name of the patient receiving trauma services.

Facility ID # -- Please use the following facility identification numbers to identify the location of the trauma center.

Trauma Center	Facility ID #	Trauma Center	Facility ID #
Johns Hopkins Bayview Medical Center (Adult Trauma Center)	01	R. Adams Cowley Shock Trauma Center	34
Johns Hopkins Hospital (Adult Trauma Center)	04	Suburban Hospital (Adult Trauma Center)	49
Peninsula Regional Medical Center (Adult Trauma Center)	08	Washington County Hospital (Adult Trauma Center)	89
Sinai Hospital (Adult Trauma Center)	10	Johns Hopkins Medical Center (Pediatric Trauma Center)	05
Western Maryland Health System (Adult Trauma Center)	20	Children's National Medical Center (Pediatric Trauma Center)	17
Prince George's Hospital Center (Adult Trauma Center)	32		

Trauma Registry # --The patient's 4 to 6 digit number assigned by the trauma nurse coordinator and reported on the Maryland Trauma Registry maintained by the Maryland Institute for Emergency Medical Services Systems.

Social Security # -- The patient's Social Security Number.

EOB # -- The explanation of benefits number that documents the services that are now subject to repayment.

Start of Service -- The date the patient arrived in the emergency department or was admitted to the hospital as an inpatient.

End of Service -- The date the patient completed the original or subsequent follow-up care.

Total Payment Received from the Trauma Fund – Amount of payment received from an insurance carrier or a third party payer.

Source of Subsequent Payment:

1=Medicaid or Medicaid MCO

2=Medicare

3=VA Benefits

4=Champus

5=Workers' Compensation Health Benefits

6=Private Health Insurance including Medicare Supplement

Other Payment Received —the amount paid in subsequent payments to the practice from other sources identified above.

Amount Returned to Trauma Fund -- If the **Other Payment Received** is less than or equal to the **Total Payment Received from the Trauma Fund,** the Amount Returned is the Other Payment Received. If the **Other Payment Received** is greater than the **Total Payment Received from the Trauma Fund,** the payment due is **Total Payment Received from the Trauma Fund.**

VERIFICATION

PHYSICIAN UNCOMPENSATED CARE LOSSES INFORMATION

I hereby certify that the facts stated in the Maryland Trauma Fund Annual Reconciliation Report are accurate and true to the best of my knowledge and that the faculty or physician practice followed and adhered to its established collection policies and procedures before submitting this application to the Maryland Trauma Physician Services Fund.

(Name of Physician Practice or Group - please print or type)

(Physician Group Designee's Name & Title – please print or type)

(Physician Group Designee's Authorized Signature)

(Date)

PLEASE RETURN REPORT AND REIMBURSEMENT TO:

Ms. Karen Rezabek
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore MD 21215

PLEASE MAKE CHECK PAYABLE TO:
STATE OF MARYLAND, MARYLAND TRAUMA PHYSICIAN SERVICES FUND

THANK YOU.